Kansas Board of Pharmacy
Landon State Office Building
900 SW Jackson, Room 560
Topeka, KS 66612-1231

State of Kansas

CANCER DRUG REPOSITORY PROGRAM
PATIENT CONSENT FORM

I, the undersigned, hereby certify that I understand the drugs I am receiving from this program have been donated. I understand that the drugs were previously dispensed to another patient and that the drugs were donated to the Cancer Drug Repository Program. I further understand that these drugs were checked for tampering, adulteration, misbranding and expiration date and that they met the conditions set forth in the statutes and regulations. That I am waiving any criminal or civil liability arising from any injury or death due to the condition of the drugs unless such injury or death is a direct result of the willful, wanton, malicious or intentional misconduct of anyone involved in the donation process.

_____ _____

Patient's Signature or Patient's Designee Date